NORTHERN THERAPY & REHABILITATION, INC

HEALTH HISTORY

Referring Doctor: ___________________ Next Doctor's Appointment: ____________ Today's Date: _____________

Patient's Legal Name: (Last)____________________ (First)_____________________ (Middle)_____________________

Date of Injury/Onset of Illness: _______________ Surgery Date: _______________

Date Stopped Work (if applicable): ________________ Job Title: _______________________________________

Date Returned to Work (if applicable): _______________ Work Restrictions: ________________________________

Area of body injured/painful - include which side: Right ☐ Left ☐ ____________________________________________

Description of current pain: ____________________________________________________________________________

Is injury related to (please circle): Auto Accident Work Other:____________________

How injury/illness happened: ___________________________________________________________________________

What aggravates your symptoms: ________________________________________________________________________

What helps alleviate your symptoms: ____________________________________________________________________

What activities of daily living has your condition limited (please circle all that apply):

Walking Sleeping Dressing Bathing Driving Other: ______________

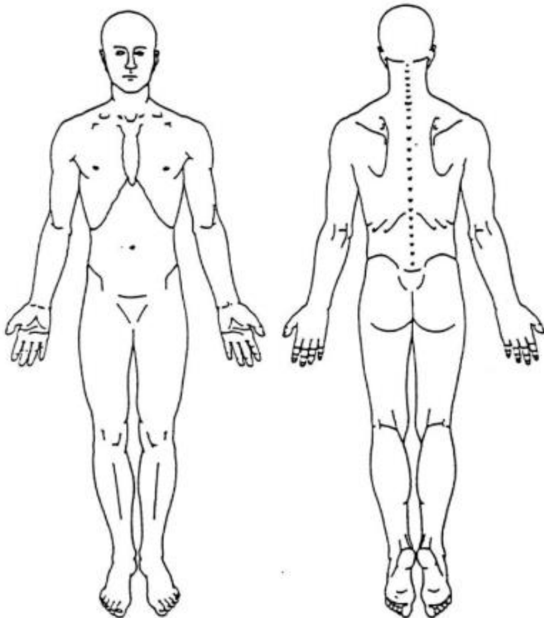
Have you had any of these tests or treatments for your present injury/illness:

| Procedure/Treatment | Date |
|---|---|
| MRI | |
| X-Ray | |
| EMG (nerve conduction) | |
| CT scan/CT myelogram | |
| Other: | |

| Procedure/Treatment | Date |
|---|---|
| Cortisone or steroid injection | |
| Spinal steroid EPIDURAL injection | |
| Chiropractic care | |
| Physical therapy | |
| Other: | |

Please indicate where your pain is located and what type of pain you feel at the present time. Use the symbols listed below to describe your pain. Do not indicate areas of pain which are not related to your present injury.

/// Stabbing XXX Burning 000 Pins & Needles === Numbness SSS Spasm @@@ Ache



Please rate your pain using the following numeric scale:

At Rest/Inactivity: ______ With Activity: _____

| | |
|---|---|
| 10+ | Maximal Pain |
| 10 | Very, Very Strong Pain |
| 9 | |
| 8 | |
| 7 | Very Strong Pain |
| 6 | |
| 5 | Strong Pain |
| 4 | Somewhat Strong Pain |
| 3 | Moderate Pain |
| 2 | Weak Pain |
| 1 | Very Weak Pain |
| 0.5 | Very, Very Weak Pain |

Please list all previous operations / surgeries / hospitalizations / illnesses / injuries / etc.:

| | Date |
|---|---|
| | |
| | |
| | |

| | Date |
|---|---|
| | |
| | |
| | |

How many falls have you had in the past 12 months: _____ If any, did you seek medical treatment for an injury: Yes ☐ No ☐

Are you allergic to any medications/drugs: Yes ☐ No ☐ If yes, please list them: ___________________________________________

Are you allergic to (circle all that apply): Cortisone Adhesive Tape Plastic Bandages Latex Rubber Rubbing Alcohol Chlorine

List all medications (including birth control and over-the-counter medications) you routinely take:

| Medication | Who Prescribed |
|---|---|
| | |
| | |
| | |
| | |

| Medication | Who Prescribed |
|---|---|
| | |
| | |
| | |
| | |

Are any of these medications new within the last 30 days? Yes ☐ No ☐

Please mark if you are currently or have previously experienced any of the following conditions:

☐ Alzheimer's
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ Cerebral Vascular Accident
☐ Current Infection
☐ Diabetes Mellitus Type ___
☐ Epilepsy
☐ Fibromyalgia
☐ Fracture or Suspected Fracture
☐ Hepatitis/Yellow Jaundice
☐ High Blood Pressure
☐ History of Cancer
Type: ______________
☐ HIV / AIDS
☐ Huntington's
☐ Immunosuppression
☐ Lupus
☐ Muscular Dystrophy
☐ Multiple Sclerosis
☐ Obesity
☐ Osteoarthritis
Area: ____________
☐ Pacemaker
☐ Parkinson's
☐ Rheumatoid Arthritis
☐ Traumatic Brain Injury
☐ Other: _________________

Do you have a rash, burn, sunburn or any other skin condition affection the area(s) to be treated? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ If yes, how many packs a day? ______________

Female patients: Are you pregnant? Yes ☐ No ☐ Are you trying to get pregnant? Yes ☐ No ☐
Please notify PT immediately if you become pregnant while under our care.

Height: ______________ Weight: ______________ BMI (to be calculated by PT): ________________

**I will advise my physical therapist if there is a change in my physical condition and/or medications which would alter my response to any questions on this form.**

**Patient Signature:** _________________________________________________________